HIPAA 5010
Frequently Asked Questions
# Table of Contents

1. **Navicure’s Online Claim Form** ................................................................. .......................... 5
   Q: Will the format change on Navicure’s online HCFA 1500 claim form? ................................. 5

2. **General 5010 Questions** .................................................................................. 5
   Q: What is 5010? .............................................................................................................. 5
   Q: What are the top 3 items for a practice to do to prepare for 5010? ...................................................... 5
   Q: What transactions are affected? ............................................................................................. 5
   Q: Who is affected by the 5010 update requirement? ..................................................................... 6
   Q: What is the implementation timetable for 5010? ...................................................................... 6
   Q: Will I need to re-enroll with payers for 5010? ........................................................................... 6
   Q: Are there certain claim types that were affected more than others? ........................................... 6
   Q: Will the compliance date be extended like it has been with other mandates? ............................ 6
   Q: Will Navicure have the ability to take 4010 info and convert it to 5010? ................................. 6
   Q: Where can I find an easy-to-understand list of all the changes associated with 5010? .......... 7
   Q: If a practice chooses not to update their practice management system to 5010 conversion prior to January 1, 2012, and relies on Navicure to produce the 5010 format, will Navicure charge additional fees for this conversion? ............................................................................................................................. 7
   Q: If I have certified EPM/EHR software can’t I just assume that my vendor is doing what is necessary to be compliant? ....................................................................................................................... 7
   Q: What if I need to receive 4010A1 remittance (835) data during or after the transition? ........... 7
   Q: What about ICD-10? .......................................................................................................... 7
   Q: Did the transition happen on a single day? ................................................................................ 7
   Q: What are transaction ‘Errata’? .................................................................................................. 7
   Q: What are the advantages of HIPAA 5010? ................................................................................. 8
   Q: Are all the commercial insurances going to follow Medicare with the 5010? If so when? ........ 8
   Q: Are there new credentialing requirements for 5010? .............................................................. 8
   Q: Will an 855I need to be filled out with Medicare? ................................................................. 8
   Q: Can you explain the changes in how a Medicare secondary claim is filed? ............................... 8
   Q: What is the difference in the January 1, 2012 and October 2013 dates that have been published? 9
   Q: Will we still be required to report Anesthesia units in addition to minutes? ............................ 9
   Q: Where can I find additional information about 5010? .......................................................... 9

3. **PO Box & Zip Code - Provider Billing Address Questions** ................................. 10
   Q: Which insurance payers will require the Provider Billing Address changes: 9-digit zip code, physical street address and PO Box as the “pay-to” address? ......................................................... 10
   Q: How do we send a PO Box as our practice address? ............................................................... 10
   Q: What if the physical street address is invalid for postal receipt? Small towns have physical address but use PO Boxes. Is this a “pay to” “bill to” problem? ......................................................... 10
   Q: How is it possible for all providers who have Lockboxes to still get payments if a physical address is required? .................................................................................................................. 10
   Q: Is it necessary to report a 9-digit zip code? ............................................................................. 10
   Q: Is the 9 digit zip code going to be necessary for all patients and physician information, or just the physician? ......................................................................................................................... 11

4. **Eligibility Questions** .......................................................................................... 11
   Q: Will the 5010 eligibility results return patient responsibility amounts? If so, will these be the real time deductible amounts that are left? ...................................................................................... 11
Q: Will eligibility include mental health benefits? ................................................................. 11

5. **Electronic Remittance Advice (ERA) Questions** .......................................................... 11
Q: If we submit claims in the 4010 format and Navicure converts to the new 5010 format, will Navicure do the same for the return of ERA payment? ................................................................. 11
Q: Will 5010 change the 835 remittance? ........................................................................ 11

6. **Paper Claim Questions** ................................................................................................. 12
Q: Are paper claims affected by 5010? .................................................................................. 12
Q: Will all carriers be required to accept claims electronically after January 1, 2012? ........ 12

7. **Institutional Claim Questions** ........................................................................................ 12
Q: How is 5010 going to affect facility UB-92 electronic claims? Will there still be a separate format for these claims? ..................................................................................... 12

8. **Testing Questions** ......................................................................................................... 12
Q: When did Navicure begin testing for 5010? .................................................................... 12
Q: What do we need to do to test for 5010 at the practice level? .......................................... 12
Q: Does Navicure have a timeline when it will test with payers? .......................................... 13
Q: Is Navicure ready to accept and test 5010 files from software vendors that are ready? ...... 13
Q: How will Navicure handle dual submission of 4010 and 5010 for claim submission of “dates of service” that should have been filed in 4010 format and newer dates of services that require 5010 format prior to mandate? ................................................................. 13
Q: Will there be dual submission or will all dates of service be submitted as 5010 regardless of date of service? ........................................................................................................ 14

9. **Acknowledgement Report Questions** .......................................................................... 14
Q: Will Navicure convert payer acknowledgement reports into readable formats? ............. 14
1. **Navicure’s Online Claim Form**

   **Q**: Will the format change on Navicure’s online HCFA 1500 claim form?
   
   **A**: Yes. This has been updated to accommodate the new 5010 requirements. The ‘pay-to’ address has been added in box 33 and the ability to add or change national drug code information are few of the changes made to assist practices in meeting 5010 requirements. This will allow clients with a PO Box to enter a physical address in the existing street address field and a PO Box in the new ‘pay-to’ address field.

2. **General 5010 Questions**

   **Q**: What is 5010?
   
   **A**: In 1996 Federal regulation, known as HIPAA, was passed that required the use of standard electronic formats between healthcare entities for such things as a request for payment due to patient utilization of healthcare services and/or facilities (837 claim), a response to a request for payment for use of healthcare services and/or facilities (835 remittance) and a request and response for patient’s eligibility and plan benefits (270/271 eligibility). Prior to this, the industry used NSF (National Standard Format) and many varied formats; the intent was to simplify the process and reduce costs - along with requiring that this information be handled in a safe and private way. While the original version, 4010, did go a long way in standardizing these transactions, data definitions and how they were used was left pretty much up trading partners to define; so, in January 2009, the HIPAA regulations were updated to require version 5010, which attempts to more rigidly define data values and how they are used. Where 4010 focused on structure, 5010 focuses on content. The 5010 update affects all healthcare entities and all HIPAA transactions.

   **Q**: What are the top 3 items for a practice to do to be 5010 compliant?
   
   1. If you currently report a PO BOX as your street address, you will need to begin reporting this as a ‘mailing’ or ‘pay-to’ address and report a physical street as your street address. This is only necessary if you currently send a PO BOX address as your practice street. Please make sure to verify any of these changes with enrolled payers before making any changes.
   2. You must send a 9 digit zip code for your practice street and facility addresses; please make sure that you are sending a 9 digit zip code.
   3. 5010 requires that dependent’s who are given a unique payer member/subscriber identifier by the payer must be reported as the subscriber. This means it will be important for your practice to be aware of when the dependent’s member ID is unique and submit these claims with the dependent as the subscriber (as you do Medicare claims today).

   **Q**: What transactions are affected?
   
   **A**: All HIPAA transactions are affected by the 5010 update and include:
   1. 270/271 Eligibility Request and Response
   2. 276/277 Claim Status Inquiry and Response
   3. 278 Service Review, Referral Certification and Authorization Request and Review
   4. 835 Payment and Remittance Advice
   5. 837 Healthcare Claim - Request for Payment
   6. 820 Benefit Premium Payments
   7. 834 Benefit Enrollment
Q: Who is affected by 5010 update requirement?
A: All HIPAA covered entities are affected by the 5010 update requirement. This includes healthcare providers, clearinghouses, payers—nearly any entity that uses or processes a HIPAA transaction type. In practice, healthcare providers must ensure that the data to support 5010 is present. Clearinghouses and payers must ensure that data is transferred in compliant 5010 structures.

Q: What is the implementation timetable for 5010?
A: HHS established January 1, 2012 as the implementation date for all healthcare entities to begin using version 5010. To ensure a smooth transition, HHS adopted January 1, 2011 as the date by which covered entities must be prepared to create and receive 5010 compliant transactions with trading partners. (This is known as Level I compliance. The January 1, 2012 implementation date is known as Level II compliance).

Important dates:
- Jan. 1, 2011 Level I compliance - ability to process 5010 transactions for testing and transition with able trading partners
- Jan. 1, 2012 Level II compliance - all covered entities must begin using 5010 transactions. However, on November 17, 2011, CMS announced it would not initiate enforcement action until March 31, 2012.

Q: Will I need to re-enroll with payers for 5010?
A: In most cases, no, re-enrollment will not be necessary. Existing NPI values will continue to be the primary method of identification. However, even though it is not expected that most payers will require new enrollment with 5010, there is the possibility that a few payers may require the practice do some sort of enrollment or make some sort of update in the payer’s system in order to enable processing past January 1, 2012.

Q: Are there certain claim types that were affected more than others?
A: Yes, some claims were affected more than others:
- Claims containing a National Drug Code value must now always contain a Drug Unit Count and a Drug Measurement Type, e.g., Gram, Milligram, etc.
- Anesthesia time must always be reported in Minutes and not Units.
- Claims where Medicare is a secondary payer must always contain the reason why Medicare is secondary – not only on the Medicare secondary claim going to Medicare, but also on claims being filed to the primary payer and Medicare is reported as the other secondary payer.

Q: Will the compliance date be extended like it has been with other mandates?
A: The compliance date was still January 1, 2011. However, on November 17, 2011, CMS announced it would not initiate enforcement action for non-compliance until March 31, 2012.

Q: Will Navicure have the ability to take 4010 info and convert it to 5010?
A: Navicure will continue to accept the 4010 version as long as necessary; however, there may some changes that practices will need to make in order to create a compliant 5010 transaction. Navicure sent 5010 Update broadcasts weekly, starting August 15th 2011 that included the changes that may need to be made by your practice. Keep an eye on your message center for more 5010 broadcast messages.
Q: Where can I find an easy-to-understand list of all the changes associated with 5010?
A: Look in the 5010 section of Navicure University for the 5010 Update. The 5010 Update document contains a list of the 5010 changes.

Q: If a practice chooses not to update their practice management system to 5010 conversion prior to January 1, 2012, and relies on Navicure to produce the 5010 format, will Navicure charge additional fees for this conversion?
A: No, Navicure will not charge additional fees for converting non-5010 data to compliant 5010 transactions; however, please make sure to read important updates you receive from Navicure Client Services that will provide guidance on changes you may need to make (or may not need to make) in order for Navicure create a compliant 5010 transactions.

Q: If I have certified EPM/EHR software can't I just assume that my vendor is doing what is necessary to be compliant?
A: It is best to double check with your vendor as far as readiness for 5010 or ICD-10 because each is so important and each has the potential to cause major cash flow problems for your practice if not done correctly. At the very least, any vendor should be able to describe how the existing functionality or planned updates meet 5010 and ICD-10 requirements. You should also inquire as to what types of tests were conducted to ensure that the types of tests represent the types of transactions and work-flow requirements of your practice.

Q: What if I need to receive 4010A1 remittance (835) data during or after the transition?
A: Check with your individual HIT vendors to see if they will allow your practice to continue receiving 4010A1 remittance data, and what steps your practice will need to take to continue receiving that data.

Q: What about ICD-10?
A: 5010 is required and must be in use to enable use of the ICD-10 code sets. That is why the law dictates the 5010 transition will occur first, followed 21 months later by the transition to ICD-10 (on October 1, 2013). ICD-10 is different from the 5010 change because it requires all of us to learn a new coding system. As part of the 5010 transition, be sure to prepare for the ICD-10 transition well in advance of the deadline.

Q: Did the transition happen on a single day?
A: As we expected, the transition to 5010 happened on a payer-by-payer basis over the course of 2011 and continues into 2012. Navicure worked with payers to establish test schedules and a transition date that assured a smooth transition.

Q: What are transaction ‘Errata’?
A: After the publication of the 5010 HIPAA standards, with more extensive review across the industry, mistakes that were in the documentation needed to be corrected. Documents describing these necessary corrections to the original 5010 documents are referred to as “Errata.” Corrections contained in the Errata typically correct typographical errors and perhaps clarify intent, and usually they do not change the intent of the original documentation. However, since these documents do describe in great detail how to process the various 5010 transactions, it is important that even minor mistakes be corrected to avoid confusion and prevent possible misunderstandings. This is why all trading partners will need to make sure that final testing is done with the Errata versions of the transactions. It is important to note that the publication of an Errata update to the transaction does not change the January 1, 2012 compliance date. The X12 837 claim, 835 payment/remittance advice, 270/271 eligibility request and response, and 834 health plan enrollment/disenrollment have Errata updates.
Q: What are the advantages of HIPAA 5010?
A: Major goals of the original HIPAA Legislation’s Transaction and Code Set section was to standardize administrative healthcare transactions to enhance the accuracy of data, reduce business cycle times, and reduce the overall costs associated with providing healthcare services. The previous transaction version, 4010/4010A1, did accomplish a standardization of the format used, but left many questions about how and when to use the many data elements up for interpretation. The 5010 update attempts to further the standardization process by more precisely defining data and how data is used between the various transactions and also greatly expands “instructions” for various common business scenarios like the describing what claim data content is necessary when coordination of benefits is necessary, and how to clearly indicate non-payment/denial decisions, to name a few.

Having both standard format, which was accomplished with the 4010 version, and content and business scenario instructions, which will be accomplished with the 5010 version, we should expect to see more electronic processing of more healthcare transactions – including more types of transactions such as eligibility and referrals, requiring less manual intervention; ultimately, the result should be better, faster, more consistent and comprehensive results with less cost.

Q: Are all the commercial insurances going to follow Medicare with the 5010? If so when?
A: Yes, all healthcare insurance companies: Medicare, Medicaid, BCBS, and Commercial insurance that accept and process electronic medical claims must do so using 5010 by January 1, 2012.

Q: Are there new credentialing requirements for 5010?
A: 5010 does not directly affect credentialing. NPI values remain the same and should be reported as you do today. UPIN numbers would be necessary only if required by a specific payer or if you are filing a claim for a non-NPI eligibility healthcare provider, you may need to supply the UPIN or state license number.

Q: Will an 855I need to be filled out with Medicare?
A: No, 5010 itself does not require new or updated 855I information. Eligible providers who are presently enrolled in the Medicare program will continue use their existing organization and rendering NPI values. However, practices needing to update their address information with Medicare would need to complete an updated 855I.

Q: Can you explain the changes in how a Medicare secondary claim is filed?
A: Today the “reason Medicare is secondary “to another payer must be reported on claims being submitted to Medicare in a field known as “Insurance Type Code” (in 2000C SBR05) and this will not change. However, with 5010, you must also report the “reason Medicare is secondary” on claims being submitted to the primary payer along with the payer information associated with Medicare, typically known as “the other payer” (in 2320 SBR05). The insurance type code reported for the other, non-destination, payer was formerly used to report what could be described as the type of plan, e.g., “Medicare”, “Commercial”, etc; these values have been removed. The only valid values that can be reported as the “Insurance Type Code” are codes that describe the reason why Medicare is a secondary payer:

Valid codes:

- 12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
- 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
- 14 Medicare Secondary, No-fault Insurance including Auto is Primary
- 15 Medicare Secondary Worker’s Compensation
- 16 Medicare Secondary Public Health Service (PHS) or Other Federal Agency
- 41 Medicare Secondary Black Lung
- 42 Medicare Secondary Veteran’s Administration
- 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- 47 Medicare Secondary, Other Liability Insurance is Primary
Q: **What is the difference in the January 1, 2012 and October 2013 dates that have been published?**
A: January 1, 2012 is the compliance date when Medicare and all payers will require that all claims be submitted using 5010. On this date payers will also be required to accept and generate 5010 transactions according to the January 2009 HIPAA legislation update. October 1, 2013 is the date when ICD-10 codes must be used on claims with dates of service on or after October 1, 2013 on professional claims and dates of discharge on or after October 1, 2013 on institutional claims.

Q: **Will we still be required to report Anesthesia units in addition to minutes?**
A: No, 5010 requires that Anesthesia time be reported only as minutes for any procedure codes that do not have a defined time period as part of its definition. You should report only the minutes, not units.

Q: **How has sending dependent information changed in 5010?**
A: 5010 claim filing was changed to reflect how all the other HIPAA transactions report the subscriber and dependent. If a payer or plan issues a unique dependent member ID, then the dependent should be reported on the claim as the subscriber and the separate dependent information would not be sent. This is how, for example, you must report Medicare and Medicaid claims today: these programs issue each subscriber and dependent their own unique member identifier, so you never report a dependent. If the payer or plan does not issue a unique dependent member ID, then you would send the subscriber information with the subscriber’s member identifier along with the dependent information (note that 5010 specifically does not allow reporting of a subscriber/member identifier with the dependent).

Q: **Where can I find additional information about 5010?**
A: Additional information about 5010 can be found through the following websites:
- ICD-10 Hub – icd10hub.com
- Centers for Medicare & Medicaid Services - [https://www.cms.gov/Versions5010andD0/](https://www.cms.gov/Versions5010andD0/)
- DISA/X12 – [www.disa.org](http://www.disa.org)
- Medical Group Management Association (MGMA) – [www.mgma.com](http://www.mgma.com)
- Workgroup for Electronic Data Interchange (WEDI) – [www.wedi.org](http://www.wedi.org)
3. PO Box & Zip Code - Provider Billing Address Questions

**Q:** Which insurance payers will require the Provider Billing Address changes: 9-digit zip code, physical street address and PO Box as the “pay-to” address?

**A:** All of the Provider Billing Address requirements are part of the 5010 specification requirements and apply to all payers.

**Q:** How do we send a PO Box as our practice address?

**A:** 5010 does not remove the ability to send a PO BOX, but it cannot be sent as your practice’s street address. If you need to send a practice PO BOX address, you must send this as your “mailing” or “pay to” address along with your practice’s physical street address. You may likely be doing this already, but please review to make sure. Your practice address must also contain a 9-digit zip code. If you need to make changes, please do so only after you have notified all of the payers you are enrolled with about these updates. Unfortunately, if these requirements are not met, when payers begin requiring 5010 (by January 1, 2012 at the latest), claims will reject.

**Q:** What if the physical street address is invalid for postal receipt? Small towns have physical address but use PO Boxes. Is this a “pay to” “bill to” problem?

**A:** Even though it is common for rural or small town addresses to use PO Box address, 5010 requires the use of a physical street address when reporting the practice’s street address. We recommend contacting your local post office to assist you in determining the most accurate way of reporting your physical street address.

**Q:** How is it possible for all providers who have Lockboxes to still get payments if a physical address is required?

**A:** 5010 allows practices to send PO Box and/or lockbox address information, but this address must be reported in addition to your street address. You will need to send your practice’s physical street address along with your PO Box or lockbox address as a “mailing” or “pay to” address. If you are not sure how to enter these addresses, please ask your practice management system software vendor, or contact Navicure Client Services and we will try to assist you in reaching out to your vendor.

**Q:** Is it necessary to report a 9-digit zip code?

**A:** Yes, 5010 does require that you report a 9-digit zip code as part of your practice’s street address and when you report a service facility address. If you are unsure what your 9-digit zip code is, please ask your local Post Office or visit www.usps.com.

**Q:** Is the 9 digit zip code going to be necessary for all patients and physician information, or just the physician?

**A:** Reporting a 9-digit zip code is required only for the practice’s physical street address and when reporting a service facility location, not when reporting subscriber or patient information.

4. Eligibility Questions

**Q:** Will the 5010 eligibility results return patient responsibility amounts? If so, will these be the real time deductible amounts that are left?

**A:** Amounts reported should reflect any amounts the patient is responsible for at the time the response was generated. The accuracy of the response will depend on if the payer’s system is correct and up-to-date.

**Q:** Will eligibility include mental health benefits?

**A:** Yes, mental health is one of the defined service types supported in the eligibility transaction. Mental health benefit details can be requested individually using service type “MH” or as part of the generic request for basic eligibility information (service type “30”).
5. Electronic Remittance Advice (ERA) Questions

Q: If we submit claims in the 4010 format and Navicure converts to the new 5010 format, will Navicure do the same for the return of ERA payment?
A: Yes, to the best of our ability, Navicure will attempt to convert 5010 remit data into 4010 remit data.

Q: Will 5010 change the 835 remittance?
A: The remittance or 835 does have some key changes. Two key changes are in the way payers are required to report denied claims and corrections or reversals.

With 4010 the remittance data contains an indicator that describes how the claim was processed by the payer. One of these values was “Denied”. In some cases, payers would report “Denied”, but not send supporting financial details. 5010 has redefined “Denied” to mean that the subscriber/dependent is not known to the payer, and it is not to be used when the claim is not being paid for contractual or other reasons.

The second change is in how reversals and corrections are reported. When a payer is reporting a reversal or correction, the payer must use a claim processing indicator of “22” which signifies a “Correction or Reversal”. In addition, all financial information should be reported exactly as it was in the original remittance data except that the amount would be reversed: all positive amounts would be reported as negative amounts and all negative amounts would be reported as positive amounts. The replacement transaction would be reported separately.

6. Paper Claim Questions

Q: Are paper claims affected by 5010?
A: The 1500 claim form will not change before the 5010 January 1, 2012 compliance date; however, the claim form is changing and those changes are under review now. The implementation date for the updated form has not been established.

Q: Will all carriers be required to accept claims electronically after January 1, 2012?
A: No, 5010 does not force payers to accept electronic claims. However, your practice may be located in a state that requires payers to accept electronic health care claims, which would then need to be in version 5010, by January 1, 2012.

7. Institutional Claim Questions

Q: How is 5010 going to affect facility UB-92 electronic claims? Will there still be a separate format for these claims?
A: Yes, 5010 does include an update to the electronic institutional claim. Note that the professional and institutional formats are still different.
8. Testing Questions

Q: When did Navicure begin testing for 5010?
A: Navicure began testing with payers and practice management system vendors in January of 2011. We are also testing with customers who wish to do so.

Q: What do we need to do to test for 5010 at the practice level?
A: This depends on whether you wish to update your practice management software so that you can produce 5010 claims or whether you wish to continue to send your current claim version (e.g. 4010).

Ideally, for either scenario, you would be able to create a test data file in a system separate from your production system.

If you are testing an updated system or new system that will generate 5010 data, you will definitely need to create test data that fully exercises this new system’s ability to create all possible claim types and filing requirements your practice processes.

If you are testing that your existing system can create compliant 5010 data, then you would want to test the scenarios where possible software updates were applied and/or you had to change data to accommodate 5010 requirements. It’s likely you would generate test data from your production system, so please exercise great care in making sure that the changes are done “long enough” to generate the test data and can be turned back to the way it looked prior to the changes.

Q: If 5010 and ICD10 are not available until January 1, 2012 and October 1, 2013, respectively, how can testing be done?
A: Implementation of 5010 and ICD-10 will happen differently. Navicure will send 5010 test claims to payers until we are confident that all customer data is properly converting to 5010. Once this happens, we will move the payer into production (i.e. 5010 will be live on the Navicure application for that payer). This happened on a payer-by-payer. ICD-10 is different in that it has a single, hard-cutover date of October 1, 2013.

Q: Is Navicure ready to accept and test 5010 files from software vendors that are ready and in production?
A: Yes, whenever you are ready, please contact Navicure Client Services at:
- Phone: (770) 342-0800
- Email: clientservices@navicure.com

Q: How will Navicure handle dual submission of 4010 and 5010 for claim submission of “dates of service” that should have been filed in 4010 format and newer dates of services that require 5010 format prior to mandate?
A: The ‘date of service’ does not determine if the claim is submitted to a payer in version 4010 or version 5010. Navicure is currently testing with all payers to make sure that claims are acceptable to that payer. Once a payer approves Navicure to begin submitting 5010 claims, Navicure maintains an internal indicator as to whether claims should be submitted to a payer using version 4010 or version 5010. As we get closer to January 1, 2012, Navicure will be submitting claims to payers using version 5010.

This is different from ICD-10. With ICD-10, claims with dates of service on or after October 1, 2013 must be sent using ICD-10 values; claims with dates of service before October 1, 2013 must be filed using ICD-9. Navicure will be able to forward both ICD-9 and ICD-10 values to payers beginning October 1, 2013.
Q: Will there be dual submission or will all dates of service be submitted as 5010 regardless of date of service?
A: 5010 refers to the format version the claims are submitted in. Once Navicure begins creating 5010 version claims for a particular payer, all claims, regardless of the dates of services, will be created and forwarded to the payer using 5010. However, if you want to send Navicure 5010 claims but a payer still requires 4010 version claims, all claims, regardless of the dates of service, will be created and forwarded to the payer in version 4010.

9. Acknowledgement Report Questions
Q: Will Navicure convert payer acknowledgement reports into readable formats?
A: Yes, Navicure will continue to link response information back to received claims, so that payer response information is displayed on-line in the Navicure application. Navicure plans to build a readable report from any reports received as a data file.